TRANSACTIONS OF THE FIFTY-NINTH ANNUAL SESSION
CALIFORNIA MEDICAL ASSOCIATION

DEL MONTE, CALIFORNIA, APRIL 28-MAY 1, 1930

This caption includes two committee reports, not included in the "Pre-Convention Bulletin" excerpts as printed in June issue of California and Western Medicine, pages 423 and 427.

HEALTH INSURANCE—A PRELIMINARY SURVEY*

By JOHN H. GRAVES, M. D.
San Francisco

Acting upon your suggestion your Committee on Medical Economics has devoted its attention exclusively to the question of health insurance; and has, in the time allotted, been able only to investigate very incompletely a very few of the many angles of this most complex question.

OUTLINE OF THE SURVEY

In order to supply you with the information upon which you might take some action, your committee has made the following studies:

1. Experience of foreign countries in health insurance.

2. Investigation of the health at time of original examination, and the diseases and their duration, of five millions of men enlisted by the United States for service in the World War.

3. Study of the incidence of illness, duration of the disability, and the cost of hospitalization and treatment of various selected groups on manufacturing, industrial and transportation activities.

4. Investigation of certain mutual benevolent hospital associations that were founded and conducted with money secured by: endowments; entrance or initiation fees; and by monthly payment of dues.

5. Frequency, duration, and character of illness of certain groups of children of school age.

6. The cost of sickness to three thousand families from January 1 to July 1, a period of six months. The cost of sickness to these families, which range in number from one in family to ten in family, have been segregated into the following items: physicians' fees; drugs; dentists; hospitals; oculists; operations; nurses' fees; dispensaries and extra household expenses.

These studies have been condensed and epitomized as much as is consistent without loss of facts secured.

PRESENTATION OF SPECIAL STUDIES

Study of the Experience of Foreign Countries in Health Insurance.—Various plans for voluntary insurance have been abandoned, one by one, for types made compulsory under the law.

The standard of living and the standard of medical service is so different from those in the United States that studies of these appear to be of little value.

I have chosen the experience tables on which the health insurance tables of Great Britain were founded, although here again we find standards so different from those in our own country that they cannot be accepted as a guide. Between the ages of twenty and twenty-five years, 25 per cent are sick each year. The average duration of the sickness is three and seven-tenths weeks, which makes an average of one week for each person insured.

Between the ages of sixty and sixty-five, 40 per cent of all insured suffer from illness annually; and the duration of the illness at that age is sixteen weeks of illness annually for each person of that age insured.

I quote these figures to call to your attention how the duration and frequency of illness increases as the age of the insured advances.

While I have tables of all ages up to eighty-five years of age, it seems unnecessary to quote them because what has just been stated will illustrate clearly the futility of making calculations of medical costs of illness from records gained from certain selected groups of employees of various industries which will be given later.

* * *

Study of Medical Care of Enlisted Americans in World War.—Statistics available as to the percentage, character, and duration of illness of the five million men enlisted by this country for service in the Great War are again of little value.

The conditions under which these men lived, so different from conditions during peace times, coupled with the fact that it was during their period of service that the world-wide epidemic of influenza occurred, make deductions of value impossible.

The fact that it took thirty thousand beds in 1924 in government hospitals to care for veterans entitled to treatment, for your purpose means nothing, because the government has no record of the sicknesses of those who served during the war unless they come under supervision when ill.

There is, however, one outstanding fact to be gleaned from our experience during the war that appeals to your committee as being peculiarly significant when considering a voluntary noncompulsory insurance plan, and that is this: that while every American soldier received automatically his enlistment compensation insurance, and life insurance had to be applied for, yet 90 per cent of all those enlisted paid for and received government life insurance; and as late as 1924 there were still 885,000 of those policies in force.

This would indicate that if the necessity for sickness insurance were properly presented in a forceful manner to the people of America that voluntary insurance would stand much better chance of success in this than in any other country in the world.

* * *

Study of Illness in Industry.—The frequency and duration of illness of employees in large industrial enterprises varies considerably with the nature of the work, location of the plant, and the age and sex of those employed. In a ten-year period, the male employees of the Edison Electric Illuminating Company of Boston had, on an average, slightly over one illness that caused absence from work per person per year for male employees, and two per year for females. In contrast, a large manufacturing concern had an average of over two cases of illness per person per year.

During a three-year period the 16,000 employees of the B. F. Goodrich Company, largely men, had an annual rate of illness per person of over one and a half cases of disabling sickness per annum.

Studies made in different places indicate that adult males lose seven to eight days per year per person, and that females lose eight to twelve on an average per year on account of sickness.

* This is the report of the Committee on Medical Economics which is referred to in the June issue of California and Western Medicine, page 427.

See also report of Dr. John C. Ruddock, which follows. Also special article in this issue by Dr. Rexwald Brown on "The Business of Medicine." These three articles interlock.—Ed.

Of 570,000 people in industrial communities studied by the Metropolitan Life Insurance Company, roughly two per cent were ill on the average of a single day.

On the basis of the lowest rate, for disabling illnesses, made by the United States Public Health Service, there would be about 130,000,000 cases of disabling illnesses in the United States every year, and if nondisabling illnesses be added, this figure would be tremendously increased.

On the basis of population, there would be in California over 5,000,000 disabling illnesses and probably 10,000,000 of nondisabling illnesses in this state each year.

* * *

Study of Mutual Benevolent Hospital Associations.—These associations range from the all too frequent fly-by-night concerns, controlled by one man or a small group, sometimes laymen, sometimes physicians, without material resources, operated for a profit, and guaranteeing treatment to the sick and hospitalization when necessary—to the old established institutions, philanthropic in character, with liberal endowments, extensive hospital properties, and with hospital staffs of reputable men.

The first type is familiar to all and has little or nothing to commend it. The second type, examples of which were established in this state as early as 1851, still conduct large modern hospitals with excellent staffs, present many features that have great interest that bear directly upon the question that you are considering. I will quote from carefully studied records of one such institution the following figures:

During the years of 1928 and 1929 there was an average membership of 9248, 70 per cent of whom resided in the city and county where the hospital is located, and a very large percentage of this 70 per cent unquestionably sought the services of their hospital or its out-patient department when ill.

During the two years mentioned, 2803 of the members were at some time patients in the hospital. The average stay in the hospital for a patient was 23.5 days and the cost per case was $103.

In the out-patient department there were 2400 visits to the x-ray department, 48,000 visits to the pharmacy, 3480 visits to the laboratory, and 7668 visits to the hydro- and electrotherapeutical departments.

The cost for hospitalization was $289,681; and the cost for the out-patient department was $90,642.

Administration expenses were $21,555.83; with a very small charge for depreciation, taxes and insurance; $419,378 was the total cost for two years' medical care, treatment and hospitalization for 9248 members. This means that it costs the organization $21.61 each year per member.

To further explain and analyze these figures, I will state that this particular society accepts into its hospital large numbers of pay patients who are not members of the organization and that these non-member patients are charged prices that give to the hospital a substantial profit.

I wish to emphasize that an examination into the accounting system shows that charges for the operation expenses are entered against the paying portion of the hospital so as to reduce the cost for the care of the members of the society wherever possible. In other words, the sum $22.61 per capita per annum would be considerably larger if the hospital were operated for members only.

I wish further to emphasize that this sum does not include any fees to the medical profession except a few modest salaries paid for supervision of x-ray and pathological departments, together with the resident physician's and interns' salaries, and possibly one or two very small staff salaries, as the staff as a rule serves without financial remuneration. No obstetrical service is given to members.

The outstanding fact of value to you is that this institution, if it charged $22.61 per person per annum for medical care without medical or surgical fees, would soon be bankrupt were it not for the fact that it has a return from investments from its endowments and gleans a profit from outside non-member pay patients.

* * *

Study of Illness in Children of School Age.—The frequency and duration of illness among children of school age varies greatly. Your committee has not been able to secure accurate data in California, but in some eastern communities they average about seven disabling days of sickness per school year (180 days); whereas in some communities in the Middle West children of school age appear to have disabling sicknesses about six per cent of all days of the year.

* * *

Study of Cost of Illness in Group of Three Thousand American Families.—I am able to present a record of the cost of sickness to 3281 American families over a period of six months from the first of January 1929 to the first of July 1929.

These families are all above the poverty line, but cannot be considered in any way as representing financially the average California family. These families range, in numbers per family, from one to nine and over, and the expenditure being for a period of six months will have to be multiplied by two to secure the estimated annual expenditure.

Of the 3281 families studied there were:

198 families that made no expenditure for sickness.
1113 families spent less than $25.
654 families spent from $25 to $49.
655 families spent from $50 to $99.
397 families spent from $100 to $199.
135 families spent from $200 to $299.
55 families spent from $300 to $399.
36 families spent from $400 to $499.
38 families spent $500 or more.

Remember that these are expenditures for six months only. Of these families there were twenty with only one in the family and the average expenditure for sickness for six months was $72, which would be $144 per year per person.

One hundred and twenty-eight families, with two in the family, expended $82 for six months, or $164 per year.

Four hundred and fifty-five families, three in the family, expended $70 in six months, or $140 yearly.

Six hundred and eighty-five families, four in the family, expended $62 in six months, or $124 yearly.

Six hundred and twelve families, five in the family, $73 in six months, or $146 yearly.

Four hundred and sixty-four families, six in family, $60 in six months, or $120 yearly.

Two hundred and ninety families, seven in the family, $80 in six months, or $160 yearly.

One hundred and ninety families, eight in the family, $93, or $186 yearly.

Ninety-eight families, nine in the family, $50, or $100 yearly.

One hundred and twenty-one families, ten and over in the family, $82 in six months, or $164 yearly.

The average cost per person ranges from $6.64 to $75.63.

The expenses incurred by these families were arranged as follows:

Twenty-three hundred and sixty-eight employed a physician during the period of six months and the fees totaled $98,359, or a total of $37 per family for six months, or $74 per annum for physicians' fees.

Drug bills for 2755 of these families totaled $29,607, or $11 for six months, or $22 per annum.

There were 988 of the families who paid $18,108 or $18 per family to the dentist, or $36 per annum.

TABLE I. SUMMARY OF INCOMES OF PHYSICIANS IN THE UNITED STATES

	Gross Income	Net Income	Expense of Practice	Savings	Living Expenses	No. of Years in Practice	No. in Family	Doctors Who Own Homes	Doctors With Home Office	Ratio of Specialists to General Practitioners
Rural practitioners	$5,727	$3,284	$2,443	$1,257	$2,027	19.	3	72%	36%	1 to 34
Doctors in towns of 5000 population	7,513	4,800	2,713	1,549	3,251	22.5	5	80.9%	17.3%	1 to 3.6
In towns of 10,000 to 25,000	10,207	6,369	3,838	2,706	3,663	19.5	5	85.6%	10.2%	1 to 2
In cities of 50,000 upward	11,379	7,022	4,357	2,639	4,383	19.2	3	72.3%	9.9%	1 to 1.7
In metropolitan centers	11,227	7,125	4,102	2,203	4,922	15.	3	39.2%	29.9%	1 to 1.3
In industrial centers	9,921	6,235	3,686	1,468	4,767	19.8	4	78.3%	30%	1 to 2.5
Average for U. S.	$9,329	$5,806	$3,523	$1,970	$3,835	19.2	4	71.4%	22.2%	1 to 7.5

Four hundred and forty-seven of these families paid hospital bills of $28,708, or $60 per six months, or $120 per annum per family.

Three hundred and eleven families paid the oculist $4815, or $15 per six months, or $30 per annum.

There were 212 operations, the fees for which were $15,779 which was an average of $74 per family for six months, or $148 for one year.

Two hundred and twelve families paid nurses' fees of $8766, or $41 per family per six months, or $82 per annum.

Extra household expenses on account of illness in 1886 families averaged $21 per family.

As will be seen from these figures, families of one, two, or three people expend more for sickness than families containing two or three times the number of persons.

It is not claimed that this in any way represents the cost of adequate care, but does give an idea as to the sums actually expended by people in extremely modest circumstances.

When we stop to consider that of all people who have attained the age of twenty years, that 89 per cent had measles, 70 per cent have had whooping-cough, 72 per cent mumps, 52 per cent chickenpox, 11 per cent scarlet fever, 10 per cent diphtheria; that there are 2,000,000 births in the registration area alone, of the United States; that on an average day there are 350,000 confined in hospitals for nervous diseases; that syphilis and gonorrhea cause one person out of a hundred to place themselves under the care of a physician; and that in a recent year there were 36,000 cases of smallpox, you will understand how futile it is to base any plan of sickness insurance upon the experience of industrial organizations furnishing treatment to adult males practically none of whom would be treated for any of these diseases or conditions.

Referring again to the cost of sickness in the three thousand families; if these figures are analyzed they show that in families up to four persons in number the actual cost per person was $76 per year. This in families of very modest incomes and the adequacy of the treatment questionable. Further it shows that the single individual spends about $145 per year for sickness which would be a little less than five per cent of a $3000 annual income.

It is to be remembered that these families are all urban families in the immediate reach of physician, hospital, nurse, and all the agencies that are brought into use for the scientific treatment of disease, and it is well to remember that the towns and cities of the great central valleys of this state in many instances are 150 to 200 miles distant from coast-line towns possessing medical facilities along the eastern border of the state; and that in the hilly and mountainous regions between the valleys and the coast, and between the valleys and the eastern borders of the state, there are many people who live from thirty to seventy-five miles from the nearest doctor; that to reach these people when ill, particularly in the winter time, requires travel over roads that are difficult, to points that not infrequently cannot be reached by automobile.

Treatment and care of such a patient under these conditions would add tremendously to the expense and could not be compared to that of the city dweller.

As the principal agitation for better medical service at lower costs is on account of the claimed inability of those of moderate income, the so-called white collar brigade, to meet the expense of illness, your committee sought to ascertain how many people in the State of California would come under this classification. Consulting the income tax department at the Custom House, we found that there were only 315,000 people in the State of California who filed statements of income, and that of this number only 185,073 pay any tax.

Of the 315,566 returns made, there were 12,585 that showed a net income of under $1000.

There were 75,500 who showed net incomes of over $1000 and below $2000, and

There were 71,000 that showed incomes above $2000, but below $3000.

This would make, according to the income tax returns, about 160,000 citizens in the state whose net incomes are below $3000.

Of course such figures are absurd, and yet there are many people of great wealth whose net income, after all deductions are made, in any single year, may be less than nothing.

As the California State Bureau of Labor Statistics is said to keep no figures on the employees of enterprises that employ less than five people, any statistics for your purpose on the size of salaries in the state would prove as useless as the figures from the Federal Income Tax Bureau just quoted.

One of the plans submitted to your committee that has a possible solution of the problem of furnished adequate medical care to the individual of small income at a price that he could afford to pay was presented by a member of your Council, Dr. F. R. DeLappe of Modesto.

The chief feature of the plan suggested consists in making each County Hospital an open hospital for all reputable members of the medical profession.

The County Hospital would establish a department, or preferably a separate building, where a charge of $3 per day would be made for hospital care. The patient would be attended by his private physician and the physician would submit a bill for fees, which would be one-half the amount customarily charged.

The bill would be submitted to and approved by the accounting and welfare departments of the hospital and then passed on to the patient for payment.

If it is a real condition that confronts us, this might be a very practical way to meet it, and after consultation with various interested people and heads of health departments, we submit it for consideration and discussion.

In view of the fact that the National Committee on the Cost of Medical Care has only published existing data that it has collected and that its researches for facts concerning this problem hitherto unknown, is only fairly well begun, your committee feels that the data they will be able to furnish as their work progresses will, when received, be of the greatest possible assistance in the development of a successful system.

Statistics on physicians' incomes are included. (Published by courtesy of editors of *Medical Economics*):

From the all too meager facts that we have been able to gather, it appears to your committee that any action toward establishing a sickness insurance plan in the near future should first be tried out in some selected town or county; second, charge per capita per annum for those whose incomes range between $1000 and $2000 per annum should be far in excess of any sum so far considered as being practical.

In conclusion, as chairman of the Committee on Medical Economics, I desire to express my appreciation of the Council's liberality and confidence in authorizing me to appoint subcommittees and expend sums necessary to accumulate needed information on this subject.

I have not availed myself of your liberal offer because I did not feel warranted in expending the society's funds without greater assurance that the data collected would prove of real value and be put to practical use.

THE CALIFORNIA "CLINIC" PROBLEM

By JOHN C. RUDDOCK, M. D.
Los Angeles

At the fifty-eighth annual session of the California State Medical Association, held at Coronado May 6 to 9, 1929, a new constitution and by-laws was adopted for the Association. Chapter 8, Section 1, of the by-laws provides for the formation of certain standing committees, which were appointed by the Council at its one hundred and eighth meeting with the consent of the House of Delegates. This committee, consisting of Dr. Gayle G. Moseley, Redlands, Dr. Walter B. Coffey, San Francisco, and Dr. John C. Ruddock, Los Angeles, have made a survey for the purpose of ascertaining facts and figures relative to the insidious growth in the various communities of the state of the number of clinics, the part that they play in the social structure of the community, and the cost of that service to the community as it affects medical economics.

How This Survey was Made

This survey has been rather a stupendous task and the data that we have gathered has become rather difficult because of the interlacing of this clinic structure with other branches of medicine. The present survey, which this committee is very pleased to report, is as complete as is possible without a paid worker investigating personally each clinic. This investigation was done by mailing approximately 1500 questionnaires to various hospital groups, clinics, and organizations working under such a name, such as groups of doctors, and various medical service groups. Early in the investigation, however, it was necessary to subdivide the work, as the field was altogether too large for one investigator to complete in the allotted time. This grouping is as follows:

Group 1. Charitable clinics.
Group 2. Industrial clinics.
Group 3. Commercial clinics.

Industrial medicine being a particular and specialized branch of medicine, under the control of the Industrial Accident Commission and regulated by the State Compensation Insurance Laws, was purposely left out of this survey, in order that confusion of this branch of medicine with the clinic situation would not be made. This survey, therefore, will include statistics obtained from charitable, semicharitable, private, and commercial clinics operated now in the State of California. Unfortunately, there are no means by which we could obtain statistics, data, costs, and other figures from private clinics, because they refused to give them to us. There are many clinics in this state—charitable, semicharitable, private, and commercial—that are run under the supervision of osteopaths, chiropractors, naturopaths, and other cults, who have deliberately refused to give us any information whatsoever, with the statement that "we are not interested in any of the activities of the California Medical Association." However, we are able to give you figures on a sufficient number of clinics and clinic activities in the State of California so that a basis of costs may be approximately ascertained.

What Is a Clinic?

Definition of Clinic.—No better definition has been found than that in the Statutes of the State of New York, which is as follows:

"For the purpose of this article a 'dispensary' is declared to be any person, corporation, institution, association, or agent, whose purpose it is, either independently or in connection with any other purpose, to furnish at any place or places, to persons nonresident therein, either gratuitously or for a compensation determined without reference to the value of the thing furnished, medical or surgical advice or treatment, medicine, or apparatus, provided, however, that the moneys used by and for the purpose of said dispensary shall be derived wholly or in part from trust funds, public moneys, or sources other than the individuals constituting such dispensary and the persons actually engaged in the distribution of charities of said dispensary."

There is likewise a definition in the Statutes of the State of Massachusetts:

"For the purpose of this act a 'dispensary' is defined to be any place or establishment, not conducted for profit, where medical or surgical advice or treatment, medicine or medical apparatus is furnished to persons nonresident therein; or any place or establishment, whether conducted for charitable purposes or for profit, advertised, announced, conducted, or maintained under the name 'dispensary' or 'clinic' or other designation of like import."

* * *

Purposes and Development of Clinics.—There are two distinct purposes for which dispensaries have been developed:

1. To collect material for the teaching of clinical medicine.

2. As a means of furnishing free treatment to the indigent poor.

The first group, the teaching clinics, are a small group and their numbers run hand in hand with the number of medical schools. It is hardly consistent for a physician who has enjoyed the benefits of a thorough medical education, the average cost being about $10,000, to object to a clinic connected with a medical school on the ground that such a clinic lessens the financial returns from private practice.

In rural districts or small cities the poor form a relatively small percentage and are not segregated. Here, each individual physician assumes a certain share of the free work in the community without allowing this to become an overwhelming burden. As the cities have grown with the drift of population to industrial centers, the relative number of dependents has increased, and, what is more important, they have collected in certain quarters or districts. The physicians in these districts would be overwhelmed by charity work if they had to assume the entire burden, and likewise, if these sick poor were forced to pay for medical treatment, they would in turn be forced to a condition of living that would in itself tend to aggravate their physical condition. This is the underlying factor in the development of clinics and medical dispensaries. In other words, they are an attempt to meet the results of economic conditions. The system is in itself inherently wrong, for often persons are forced by it to accept private charity for what in reality is a condition for which society as a whole is to a large extent responsible. It should not be necessary for a few individuals and the medical profession as a whole to bear the burden of these economic conditions.

Outgrowth.—The outgrowth from the above purposes for which clinics have been organized has led to the development since 1910 and to the organization in this state of a large number of associated clinic groups. These clinics are maintained by hospitals, governmental and private health organizations, industrial and commercial establishments, trade-unions, courts and prisons, and charitable agencies. Besides these are "pay clinics" and "group clinics." In these two last named are gathered together a man with experience in general diagnosis and one or more specialists, with more or less complete equipment for providing medical service, all under single administrative control. While "group clinics" are not usually organized for the purpose of reducing fees, "pay clinics" charge fees approximately covering the cost of the service, including remuneration for the physicians. Quoting from the Committee on the Cost of Medical Care, Dr. Ray Lyman Wilbur, chairman, states: "There has been a tremendous growth in the number of clinics from about six hundred in 1910 to almost six thousand in 1926."

Somewhat different from the clinic is the health center, which promotes and coördinates medical service and related social service and educational work. It brings together under a single roof a large number of previously scattered activities for the prevention of disease, and the promotion of health. In our large communities there have been developed a great number of health centers. These have been both under city and county control. Their primary function is educational health surveys, and irradication of communicable disease. They offer to the public free of charge services in regard to:

1. Treatment of venereal diseases.
2. Diagnosis and treatment of tuberculosis.
3. Advice in regard to baby welfare.
4. Vaccinations against smallpox, diphtheria, scarlet fever.
5. Dental care.
6. General advice in regard to all health problems.

California Laws Regarding Clinics

Licensing of Clinics.—In the State of California there is no law or statute that determines, specifies, or controls the number or the kind of clinics. Any individual in this state may start a clinic at any time he desires for any purpose that he may desire at any place that he may desire. This clinic may be owned, controlled and standardized by any lay individual. It might be of interest to note that all regulation of existing clinics is done by their respective boards of directors. Therefore, we have as many clinics doing as wide a variety of medical work as we have varieties of boards of directors. There is no set standard of any kind adopted or followed by the clinics of this state. This is not strange when compared with the rest of the nation.

In order to secure information concerning the state laws governing the licensing and control of out-patient departments of hospitals, clinics and dispensaries, letters were sent to all the state departments of health. Replies have been received from thirty-nine states. Thirty-six of these have no state laws regulating the licensing and supervision of out-patient dispensaries. New York, Ohio, and Massachusetts, all have regulating statutes for clinics. In New York all the dispensaries are under the supervision of the State Board of Charities, which has power to license them and to regulate their management. In Ohio the State Department of Health has authority to license and require reports from all hospitals and clinics. In Massachusetts a law enacted in 1918 authorized the State Department of Health to license all dispensaries and to establish regulations concerning them.

* * *

A copy of the General Acts of Massachusetts, 1918, Chapter 131, page 106, is as follows:

"Chapter 131. *An act to require that dispensaries shall be licensed by the State Department of Health.*

Be it enacted, etc., as follows:

Section 1. For the purpose of this act a dispensary is defined to be any place or establishment, not conducted for profit, where medical or surgical advice, or treatment, medicine, or medical apparatus is furnished to persons nonresident therein; or any place or establishment, whether conducted for charitable purposes or for profit, advertised, announced, conducted, or maintained under the name 'dispensary,' or 'clinic,' or other designation of like import.

Sec. 2. It shall be unlawful for any person, firm, corporation or association, other than the regularly constituted authorities of the United States, or of the commonwealth, to establish, conduct, manage or maintain any dispensary, as above defined, within the commonwealth, without first obtaining a license as hereinafter provided.

Sec. 3. Any person, firm, association or corporation, desiring to conduct a dispensary shall apply in writing for a license to the State Department of Health. The application shall be in the form prescribed by the said department, and shall be uniform for all schools of medicine. There shall be attached to the application a statement, verified by the oath of the applicant, containing such information as may be required by the said department. If, in the judgment of the said department, the statement filed and other evidence submitted in relation to the application indicate that the operation of the proposed dispensary will be for the public benefit, a license in such form as the said department shall prescribe, shall be issued to the applicant. Licenses shall expire at the end of the calendar year in which they are issued, but may

be renewed annually on application as above provided for their initial issue. No license shall be transferable except with the approval of the said department. . . . The fees shall be paid into the treasury of the commonwealth.

Sec. 4. The public health council of the said department shall make rules and regulations, and may revise or change the same, in accordance with which dispensaries shall be licensed and conducted, but no such rule or regulation shall specify any particular school of medicine in accordance with which a dispensary shall be conducted.

Sec. 5. The commissioner of health and his authorized agent shall have authority to visit and inspect at any time any dispensary, in order to ascertain whether it is licensed and conducted in compliance with this act and with the rules and regulations established hereunder. After thirty days' notice to a licensed dispensary and opportunity to be heard, the said department may, if in its judgment the public interest so demands, revoke the license of any dispensary.

Sec. 6. Dispensaries legally incorporated or in operation in this commonwealth at the date of the passage of this act shall, on application, be permitted to continue in operation for the remainder of the calendar year without fee. The said department is hereby directed to cause an inspection to be made of all such dispensaries prior to the thirty-first day of December in the current year.

Sec. 7. Any person, firm, association or corporation advertising, conducting, managing, or maintaining a dispensary as defined in this act, unless the same is duly licensed under this act, and any person, firm, association, or corporation wilfully violating any rule or regulation made and published under the authority of this act, shall be guilty of misdemeanor, and, on conviction thereof, shall be punished by a fine of not less than ten dollars nor more than one hundred dollars. A separate and distinct offense shall be deemed to have been committed on every day during which the violation is given in writing by the said department to the authorities of the dispensary concerned. It shall be the duty of the commissioner of health to report to the attorney-general any violation of this act.

Approved April 2, 1928."

How Other States Handle Clinics

Excerpts From Letters Received From Different State Boards of Health

1. Arizona: "Social service centers in larger towns supervise the clinics."

2. Arkansas: "State Health Department operates no clinics except on free basis for those unable to pay. Clinics established by private or official agents or hospitals not coöperating with State Board of Health have their own policies, according to the directors in charge."

3. Colorado: "There is no state law providing distinctly for clinics and outdoor treatment. However, there are several health and welfare units which conduct clinics at various times and places simply by regulation and agreement, but not distinctly by statutory provision."

4. Georgia: "Not licensed or supervised."

5. Idaho: "Supervision of hospitals and clinics is by county health board or the respective boards of county commissioners."

6. Illinois: "Local communities, under the police power of the state may establish and regulate clinics, dispensaries and out-patient departments by ordinance."

7. Indiana: "Clinics and dispensaries in cities are under supervision of city health departments and subject to such regulations as the health departments may adopt. Same is true of out-patient departments of city hospitals. Private hospitals conduct their out-patient departments under such rules and regulations as the hospital governing boards adopt."

8. Kansas: "So far as I know, the hospital itself regulates and provides for the medical attention given the clinic patients."

9. Michigan: "Supervised only by the management of the various hospitals to which they belong."

10. New Hampshire: "Hospitals have supervision over any work relating to hospitals; tuberculosis clinics under supervision of New Hampshire Tuberculosis Association. Venereal Disease clinics under supervision of the State Board of Health."

11. North Dakota: "Not supervised at this time."

12. Oregon: "Practically no supervision of these clinics. However, they are usually conducted by members Oregon State Medical Society. There are one or two outlaw clinics having no supervision whatever."

13. Pennsylvania: "Department of Welfare shall make necessary investigation to ascertain whether any dispensary, clinic, or hospital applying for a charter is needed in the community, opinion of the department shall be forwarded to Court of Common Pleas, but shall not be final in decision re granting of charter."

14. Rhode Island: "Controlled by the respective hospitals."

15. Texas: "(1) City clinics for treatment of indigent sick under city health departments. (2) Out-patient departments of hospitals are under jurisdiction of hospital which must be registered; only licensed physicians are supposed to conduct examinations and treatments. (3) Concerning private clinics operated by groups of physicians, the only requirement is that physicians be registered M. D.'s."

16. Virginia: "Most of the clinics are connected with either medical colleges, general hospitals, or the City Health Department."

17. West Virginia: "Very few out-patient departments of hospitals. Bureau of Venereal Disease (State Department of Health) has supervision of twelve venereal disease clinics; tuberculosis clinics are supervised by the State Tuberculosis Association; preschool clinics are supervised by the respective divisions of the State Department of Health."

18. Wisconsin: "Such regulations as are imposed are of local origin through city councils or county boards."

A survey of this character quickly brings out the fact that there is a very marked duplication of work of the various clinics in any large community. There have been a few surveys made attempting to compile the existing material for the health problems of a community. These surveys have all been under departments of social welfare or community chests. There is no data available that would specify or attempt to state when a saturation point in regard to clinics and hospitals has been reached. This saturation point is naturally a fluctuating one, dependent first upon the rate of growth of the community, and secondly, the fluctuations of the economic situation in that community.

Some Clinic Evils

Evils That Regulate the Number of Clinics in a Community.—1. Religious organizations are vying with each other, and establishing competitive clinic groups in the same locality, which necessitates separate estab-

lishments, separate capital investments, separate staffs, separate nurses, separate social service departments.

2. Social groups, such as women's clubs, fraternal organizations, likewise establish health centers and clinics as a part of their social welfare program and in order to justify their existence.

3. Politics also is a factor in establishing unnecessary organizations and groups.

* * *

Social Service Agencies.—Social service groups have developed because economic dependency goes hand in hand with physical and mental disease, ignorance, crime, juvenile delinquency, and a combination of these factors results in misery and premature death. The social service groups have been responsible for the development of the clinic situation as we have it today. However, one must state that those clinics that are under large social service groups, such as community chests, are the best clinics that we have in this state today. They have attempted in a meager way to set standards for these clinics, both economical and medical. They, however, are responsible for a great many unnecessary clinical groups. They are responsible for such health surveys as are available for any community at the present time. The medical profession has not seen fit to make such health surveys and surveys of medical facilities in this state. Social welfare is well organized. They have a well-organized department as a part of the state offices, the Department of Social Welfare, and in the large cities there is also established subsidiary offices of this department. They have established sets and standards of procedure in regard to various activities, and no social service groups can organize without the sanction of this department. There has, therefore, come to be recognized a profession known as a medical social worker. This profession has been developed with the development of clinics where it is necessary to have social investigations in regard to clientele patronizing such places. This is the crux of the situation. Who is eligible to attend these clinics? We often feel that many people attend clinics who should not do so. In order to ascertain those eligible for service at a clinic many factors must be taken into consideration, and only one who is trained in this investigation can possibly ascertain the facts of eligibility. A survey made at the Washington University Dispensary at St. Louis revealed that the number of people who take advantage of clinic work that are not entitled to it is small and but two per cent. This percentage varies with the efficiency of the investigation given each dependent patient. Various means suggested to eliminate this two per cent are impractical. Quoting from a statement prepared by Michael M. Davis for the Public Health Federation of Cincinnati, Ohio, concerning the patient's ability to pay:

"Medical service in hospitals and clinics needs to be regarded from four points of view:

(a) That of *the patient* who needs certain medical service.

(b) That of *the community,* which is interested to see that patients secure what they need even if they are unable to pay for it.

(c) That of *the physician,* who is the main professional agent in rendering medical service.

(d) That of *the hospital or clinic,* the institution which administers the service.

Fees Paid by Clinic Patients

On what basis should the ability to pay for medical service be determined?

There are three primary elements to be considered:

1. *The income of the patient or family* considered on an annual basis.

2. *The size and constitution of the family,* affecting as these do, the necessary expenses.

3. *The cost of the medical service* required by the patient.

Emphasis needs to be laid on considering irregular or seasonal earnings in the estimation of annual rather than monthly or weekly income, of including supplementary as well as main sources of income; and of ascertaining debts and other financial obligations.

The paying ability of a family is substantially affected by its constitution. A family of adults, for example, differs decidedly in its needs from one with the same income composed of parents with several young children. Elderly parents or relatives who must be supported may have to be considered as part of the family group even though they reside elsewhere.

The diagnosis of a disease may cost, at private rates, from a few dollars to several hundred dollars. The cost of treatment varies even more widely. Obviously, the ability of a patient to pay depends not so much upon his financial resources as upon the relation between his resources and the cost of the services which are required. The duration of an illness must also be considered, both as affecting expense and also as causing loss of income if the patient is a wage-earner.

Patients ordinarily able to pay for private medical care may be temporarily in the clinic or ward group because of accident or misfortune. Patients may be able to pay for private care or full hospital rates for a minor or short illness, whereas for a major operation, or for an illness requiring specialized or expensive service they would fairly receive care at reduced or free rates in a hospital or clinic. On the other hand, the paying ability of a family may be increased by judicious budgeting or arrangements for time payments.

Great stress should be laid on the importance of a skilled person in immediate charge of the admission of patients. The qualities needed are tact, business sense, training and experience in interviewing and managing people, and knowledge of living conditions, and community resources.

There are certain medical situations, such as emergency cases, and cases of communicable disease, which override financial considerations, and require the admission of the patient for at least one treatment."

The Clinic Problem Is an Urban Problem

The Clinic Is a City Problem.—The clinic problem affects only large centers of population.

* * *

Location of Clinics.—It has long been felt that a clinic should be placed in that part of the city or community where the laboring classes are housed or where the population is thickest with that class of people who might be eligible for clinic service. In order to investigate this phase of the problem a clinic was selected in the city of Los Angeles which was located in the railroad yards at the edge of a Mexican district in a portion of the city which was almost inaccessible by street car from other portions. A map was kept and pins were inserted for each new patient that applied at the clinic for a period of two years. The results were very surprising. It was found at the end of this period of time that the pins were evenly distributed throughout the entire city and surrounding suburban districts without any regard as to the locality of that clinic. Unfortunately it was realized

at the time the survey was completed that 50 per cent of the patients attending this clinic were referred through a religous welfare organization. However, the conclusion that the essential feature in location of a clinic is that it be located in the community at a point that is easily accessible to street car service, is justified.

Cost of Clinics.—The personnel involved in rendering service to any one patient applying at a clinic is as follows:

1. Director or manager of clinic.
2. Social service worker.
3. File clerk.
4. Nurse.
5. History clerk (usually volunteer).
6. Doctors (volunteer, usually more than one).
7. Laboratory technician.
8. Janitor.
9. Field social worker.
10. Various workers connected with central office of social service branches.

The cost of caring for patients in any clinic is dependent on the total number of indigents visiting that clinic. There must be a sufficient number to justify the number of the personnel necessary to run the clinic. A small clinic, then, becomes a rather formidable economic problem.

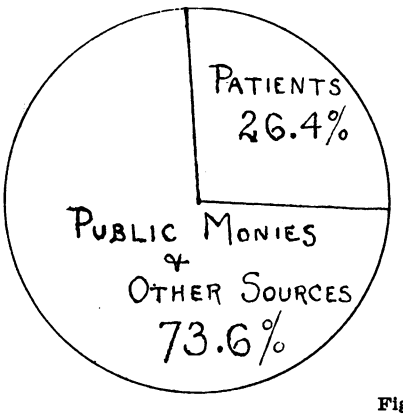
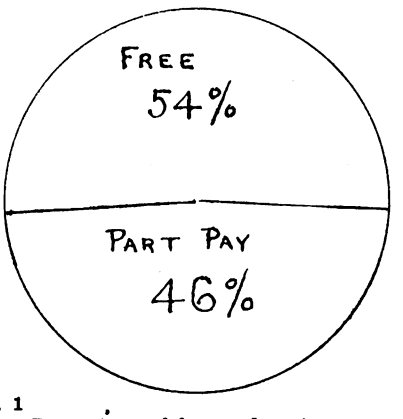


Fig. 1

Percentage of moneys collected from patients attending charitable clinics in the State of California in relation to the total income of clinics.



Percentage of free and part-pay patients attending charitable clinics in the State of California.

Operation Costs

Cost of Operation.—The average total cost per charitable clinic in the State of California is $12,398.50. This includes 175 charitable clinics, and does not include the emergency hospital services of either Los Angeles or San Francisco. The average total income received from patients per clinic is $1680.25. Now, inasmuch as there are 6870 average visits per year for each clinic, then the average amount collected per visit would be $0.259. Inasmuch as $1680.25 is the average amount that each clinic collects from patients, and 54 per cent of these people are free patients, then the average amount collected from those individuals who pay is $0.479. This, however, is not the total cost per visit, which is $1.78. The clinic patient, therefore, pays 26.4 per cent of the total cost of his care. This average was ascertained from a computation of the total costs of all the charitable clinics in the State of California, and the number of visits made to these clinics.

The source of moneys for the operations of clinics and dispensaries, in addition to that paid by the patient, which amounts to 73.6 per cent, is derived from the following sources:

(a) Taxation and public moneys.
(b) Voluntary contributions and donations.
(c) Drives and subscriptions.
(d) Endowments.
(e) Private resources.

The greater portion of this money is derived from taxation and public moneys, subscriptions, and drives. The exact percentages are not available.

How, then, is this money spent?

Eighty-three cents of every dollar spent in the administration of charitable clinics goes toward salaries of the personnel necessary to conduct the clinic. Seventeen cents of the dollar is spent in rent, taxes, interest, and incidentals. Medicines are sold at cost, laboratory work is done at cost, and the services of the physicians are gratis, with the exception of those clinics run in connection with medical schools and government institutions, where the doctors receive a salary for services rendered. One can easily see, then, from the above that, in order to pay doctors for services in charitable clinics, there must be a complete reconstruction of the economic administration of these clinics, or else there must be collected from the patients attending these clinics an additional sum of money necessary to pay the physicians adequately. Under the present methods of clinic administration this appears to be practically impossible, unless some solution or plan can be arrived at in order to cut down the tremendous overhead occasioned by a large administrative personnel.

In order to show more clearly the above point, comparison is here made between San Francisco County and Los Angeles County.

County	Number of Clinics	Number of Visits	Cost
San Francisco	14	452,229	$ 504,345.78
Los Angeles	134	489,286	1,250,305.09

Although there are approximately the same number of visits made to clinics in San Francisco County as in Los Angeles County, there is a great difference in

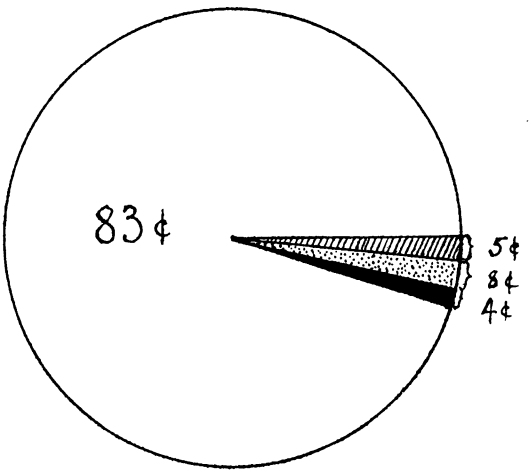


Fig. 2.—How the average clinic dollar is spent

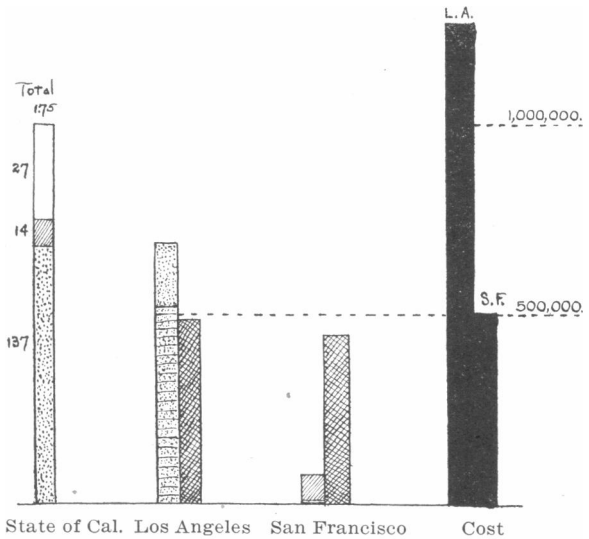
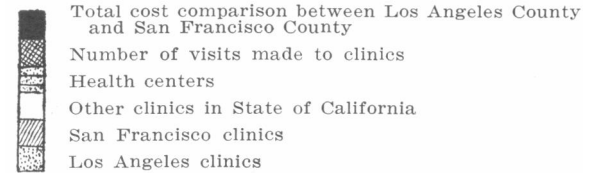


Fig. 3.—Diagram showing some relative comparisons for state as a whole, Los Angeles and San Francisco



cost. (The above figures do not include the San Francisco or Los Angeles emergency hospital service.) The average cost per visit for Los Angeles County charitable clinics is $2.55. The average cost per visit for San Francisco County charitable clinics is $1.11. The reason for this discrepancy is the fact that there are too many clinics in Los Angeles County. Centralization of clinical work into large clinics would very materially cut down such a stupendous overhead. In Los Angeles County 106 of the 134 clinics are under the jurisdiction of the various health departments. In San Francisco County two of the fourteen clinics listed are under the jurisdiction of the health department.

Medical Profession Must Lead in Regulation of Clinics

Standard of Medical Practice.—Much criticism is dealt the clinics in large localities by the medical profession, and practically all criticism is to the point that clinics usurp the patients of private doctors. Such criticism at the hands of the doctors does not help to curb the number of clinics in a locality, nor does it help to decrease the cost of medical care as it concerns the community at large. All of the charitable clinics that have reported in the state of California have well-organized social service departments for investigating the eligibility of patients attending clinics.

The standard of medical practice as carried on in a great many clinics is not a credit to the medical profession. Because of lack of time and inadequate number of doctors attending the clinics, examinations are hurried, incomplete, and inadequate records are kept. Because the service of the physician is volunteer, only those members of the profession are available who are able to give time from their practices. Many of the more desirable doctors of the community are therefore not available. If the clinics were required to give the highest type of recognized medical service to the patients attending them, then many of the poorly conducted smaller institutions would be forced to close their doors.

The plea, then, would be to raise the standard of medicine in all of the charitable clinics of the State of California. The medical profession from time immemorial have been the leaders in matters of public health and public medicine. The clinic situation has grown so fast in late years that it is almost out of control, and unless the medical profession regulates the standard of medical practice for these institutions, then the social service departments will regulate it for them.

Types of Clinics in the State of California

(1) Charitable clinics, 80 per cent.

(2) Private clinics, 9 per cent.

(3) Commercial clinics, 11 per cent.

Note: This survey does not include those clinics and out-patient departments coming under the jurisdiction of the Compensation Insurance Act.

Some California Clinic Statistics

A. (1) Charitable clinics in the State of California, 175.

(2) Total visits made to these departments for one year (175 clinics), 1,195,390.

(3) Total number of free patients seen, 646,110.

(4) Total number of new patients seen for these clinics, 235,470.

(5) Total amount of money collected from patients, $290,679.25.

(6) Total cost of operation of these clinics, $2,132,555.01. Average cost per visit is $1.78.

B. Charitable clinics are located in the following cities:

Alameda, Belmont, Berkeley, El Monte, French Camp, Loma Linda, Long Beach, Los Angeles, Martinez, Monrovia, San Diego, Oakland, Orange, Pasadena, Riverside, San Francisco, San Bernardino, Sacramento, Stockton, and Visalia.

C. Health departments maintain clinics in the following counties:

Los Angeles, San Francisco, San Joaquin, Santa Barbara, Tulare, Ventura, Alameda, Contra Costa, Madera, Orange, Riverside, Sacramento, San Bernardino, and San Diego.

D. Counties where hospitals maintain no out-patient departments separately.

Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Eldorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, San Benito, San Luis Obispo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

E. Private clinics in the State of California are as follows:

(Costs on these clinics are not available because many of the managers or owners could or would not give them to us.)

Alameda County:
Hayward Clinic.....Hayward

Fresno County:
Fresno Clinic.....Fresno

Monterey County:
Grace Deere Metabolic (in construction).....Monterey

Orange County:
Johnson-Wicket Clinic.....Anaheim
San Clemente Hospital and Clinic.....San Clemente

Riverside County:
Riverside Clinic ..... Riverside
San Bernardino County:
Savage Clinic ..... San Bernardino
Santa Barbara County:
Santa Barbara Clinic ..... Santa Barbara
Clinic of Medical Arts ..... Santa Barbara
Sonoma County:
Santa Rosa Clinic ..... Santa Rosa
Yolo County:
Woodland Clinic ..... Woodland
San Diego County:
Les Invalides ..... San Diego
Surgical Clinic ..... San Diego
Rees-Stealy Clinic ..... San Diego
Children's Clinic ..... San Diego
San Diego Clinic ..... San Diego
California Clinic ..... San Diego
Scripps Metabolic Clinic ..... La Jolla
San Francisco County:
Free Service Clinic ..... San Francisco
Greens' Eye Hospital ..... San Francisco
Mount Moriah Hospital ..... San Francisco
Western Medical Service Corporation ..... San Francisco
Kearny & Geary Clinic ..... San Francisco
F. Justin McCarthy and Staff ..... San Francisco
La Societe Francaise de Beinfaisance Mutuelle ..... San Francisco
German General Benevolent Society ..... San Francisco
Los Angeles County:
California Clinic ..... Los Angeles
Los Angeles Medical Group and Clinic ..... Los Angeles
Roos Loos Clinic ..... Los Angeles
Soiland Clinic ..... Los Angeles
Children's Clinic of Los Angeles ..... Los Angeles
Los Angeles Clinical Group ..... Los Angeles
Monrovia Clinic ..... Monrovia
Los Angeles Clinic and Hospital Assn. ..... Los Angeles
Hollywood Clinic ..... Hollywood
Seaview Clinic ..... Long Beach
Radium and Oncologic Institute ..... Los Angeles
Marian Davies Foundation ..... West Los Angeles
Baptist Christian Center ..... Los Angeles
Vienna Health Institute ..... Los Angeles
Viscose Ambulatorium ..... Los Angeles
Belvedere Clinic ..... Los Angeles
Children's Clinic ..... Los Angeles
Emergency Clinic ..... Los Angeles
Los Angeles Cancer Hospital and Clinic ..... Los Angeles
Los Angeles Express Better Baby Clinic ..... Los Angeles
Long Beach Telephone Clinic ..... Long Beach
Edwin Larson Hospital and Clinic ..... Los Angeles
Los Angeles Diagnostic Clinic ..... Los Angeles
Los Angeles Tonsil and Adenoid Clinic ..... Los Angeles
Mothers' Clinic ..... Los Angeles
Moore-White Clinic ..... Los Angeles
Medical Clinic ..... Los Angeles
MacLean Clinic ..... Los Angeles
Manchester Hospital and Clinic ..... Los Angeles
Neighborhood Settlement Clinic ..... Los Angeles
Pacific Coast Proctological Clinic ..... Los Angeles
Pershing Square Clinical Group ..... Los Angeles
Dr. A. E. Pike Clinic ..... Long Beach
Solar Clinic and Sanatorium ..... Los Angeles
Vermont Clinic ..... Los Angeles
Vermont Tonsil Clinic ..... Los Angeles
Vermont Medical Clinic ..... Los Angeles
Women's Clinic and Maternity Service ..... Los Angeles
Watts Suburban Clinic ..... Los Angeles

Private Hospitals With Out-Patient Departments

(This is only a partial list as gathered from questionnaires which were sent out. Complete lists will be printed in later reports.)

Los Angeles County:
Alhambra Hospital, Inc. ..... Alhambra
Good Hope Hospital Association ..... Los Angeles
Methodist Hospital ..... Los Angeles
San Pedro General Hospital Association ..... San Pedro
Eye and Ear Hospital Clinic ..... Los Angeles
Long Beach Community and Seaside Hospital ..... Long Beach
Tichenor Orthopaedic Clinic ..... Long Beach
White Memorial Hospital ..... Los Angeles
Barlow Sanatorium Association ..... Los Angeles
Calaveras County:
Bret Harte Sanatorium ..... Murphy
Lassen County:
Westwood Hospital ..... Westwood
Riverside Hospital ..... Susanville
Mariposa County:
Yosemite National Park (Government) ..... Yosemite
San Bernardino County:
Loma Linda Sanatorium and Hospital ..... Loma Linda
San Diego County:
Paradise Valley Sanatorium and Medical Clinic ..... San Diego
San Diego Hospital ..... San Diego
San Francisco County:
St. Luke's Hospital ..... San Francisco
Shriners' Crippled Children's Hospital ..... San Francisco
Santa Barbara County:
St. Francis Hospital ..... Santa Barbara
Cottage Hospital ..... Santa Barbara
Santa Clara County:
Sunnyholme Preventorium ..... San Jose
Alameda County:
Fabiola Hospital ..... Piedmont

Conclusions

I. Legislation is needed:
   (a) To define clinic or dispensary.
   (b) To create a bureau or sub-bureau for the purpose of:
      (1) Standardizing the type of medical practice in these dispensaries or clinics.
      (2) To license clinics.
      (3) To meet the needs of various communities in regard to dispensaries and clinics.

II. Standardization of medical practice in clinics and dispensaries is important, and is the biggest factor in curbing the number of irregular and small clinics.

III. Centralization of clinics is a big factor in the economics of clinical practice, as evidenced by the total cost of San Francisco as compared with Los Angeles, where approximately the same number of visits were made.
   (a) Centralization of health units, such as city, county, and school departments, in large centers of population would cut down materially the total cost.

IV. The administration of clinics should be in the hands of the medical profession, and various other departments should be subsidiary ones.
   (a) Medical social service.
   (b) Medical nursing service.

V. The operation of clinics and dispensaries with free medical care by religious organizations, insurance companies, clubs, fraternal organizations, newspapers, etc., for the sole purpose of furthering their own respective ends, is to be deplored. It is still further to be deplored if volunteer medical service is requested for such institutions.

VI. A survey of the medical facilities of the state should be undertaken by the California State Medical Association with a full-time man and clerical help, in order to get statistics on the vast number of private and irregular clinics and groups, who are preying on the public under the name of clinic, which is a word that has been coined and developed by the medical profession and has become generally recognized as a place where one can get the best of medical care at a nominal cost. It is up to the medical profession to protect its good name and curb the activities of such irregular groups by curbing their use of the word "clinic."

VII. The cost of caring for patients in any clinic depends on the total number of individuals visiting that clinic. There must be a sufficient number to justify the number of the personnel necessary to conduct such a clinic. The small clinic has no business to exist.